

EMPLOYER INFORMATION

Legal Name of Employer _____

Address _____

City, State, Zip _____

Employer Tax I.D. Number _____

Date Incorporated _____

Operating Pursuant to the State Laws of _____

Nature of the Business _____

Web page _____

Total number of Employees: _____

Total number of Participants: _____

Are there any current COBRA Participants or Qualified Beneficiaries on the Plans? **Yes** _____ **No** _____
If Yes, please complete the Benefit Information below for both the current year and previous year.

Total number of Current COBRA Participants: _____

Total number of Current Qualified Beneficiaries: _____

Contact Information

Name _____

Title _____

Telephone Number _____

E-mail _____

Fax Number _____

Billing Address (if different than Employer address) _____

Please complete the Benefit Information below for all COBRA eligible benefits. COBRA eligible benefits include:
HMOs
Group Insurance plans in which employees pay the premiums
Self -Insured medical reimbursement plans
Employee Assistance Plans
Health Flexible Spending Accounts
Defined Contribution (DC) Health Plans, including Health Reimbursement Accounts (HRAs)
Discount Programs
Wellness Programs
Treatment programs and clinics maintained by the employer (except first aid care provided free of charge to employees during working hours.

THE MONTHLY PREMIUM RATES ARE THE CARRIER COSTS WITHOUT THE 2% COBRA ADMINISTRATION FEE

COBRA Determination Plan Year: _____

Note: The COBRA Determination Plan Year is the year that COBRA rates are determined and frozen for that 12 month period. The beginning of the COBRA determination year is when you are allowed to change the COBRA rates and usually coincides with open enrollment of all benefits (under the Cafeteria Plan Year). However, if there is a rate renewal during the Determination Plan Year, you can not pass the rate increase on to COBRA participants until the beginning of the new Determination Year.

Open Enrollment Date for all Pre-tax Benefits: _____

BENEFIT INFORMATION

MEDICAL/PRESCRIPTION DRUG BENEFIT

Effective _____ Rates Change _____

- Tier Name:** **Monthly Premium Rates:**
- Employee Only _____
 - Employee + One _____
 - Employee + Two _____
 - Employee + Spouse _____
 - Employee + 1 Child _____
 - Employee + 2 Child _____
 - Employee + Family _____
 - Individually Rated _____ (attach copy of rates)
 - Flat Rate _____
 - Other _____

What are the age limits of the Plan?
Dependent Age: _____ Student Age: _____

- Date Termination of Coverage Becomes Effective:**
- End of Month
 - Date of Termination/Date of COBRA Event
 - 30 Days After Termination
 - End of Following Month After Termination
 - 15th or 31st

Carrier Information

Carrier Name _____
Name of Plan: (HMO, PPO) _____
Group # _____
Contact _____
Phone # _____
Address _____
City, State, Zip _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

DENTAL BENEFIT

Effective _____ Rates Change _____

- Tier Name:** **Monthly Premium Rates:**
- Employee Only _____
 - Employee + One _____
 - Employee + Two _____
 - Employee + Spouse _____
 - Employee + 1 Child _____
 - Employee + 2 Child _____
 - Employee + Family _____
 - Individually Rated _____ (attach copy of rates)
 - Flat Rate _____
 - Other _____

What are the age limits of the Plan?
Dependent Age: _____ Student Age: _____

- Date Termination of Coverage Becomes Effective:**
- End of Month
 - Date of Termination/Date of COBRA Event
 - 30 Days After Termination
 - End of Following Month After Termination
 - 15th or 31st

Carrier Information

Carrier Name _____
Name of Plan: (HMO, PPO) _____
Group # _____
Contact _____
Phone # _____
Address _____
City, State, Zip _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

VISION BENEFIT

Effective _____ Rates Change _____

Tier Name:**Monthly Premium Rates:**

- Employee Only _____
- Employee + One _____
- Employee + Two _____
- Employee + Spouse _____
- Employee + 1 Child _____
- Employee + 2 Child _____
- Employee + Family _____
- Individually Rated _____ (attach copy of rates)
- Flat Rate _____
- Other _____

What are the age limits of the Plan?

Dependent Age: _____ Student Age: _____

Date Termination of Coverage Becomes Effective:

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- End of Following Month After Termination
- 15th or 31st

Carrier Information

Carrier Name _____

Plan Name: _____

Group # _____

Contact _____

Phone # _____

Address _____

City, State, Zip _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

HEALTH REIMBURSEMENT ACCOUNT (HRA) BENEFIT

Effective _____ Rates Change _____

Monthly COBRA Premium Rate _____

Carrier Information

Carrier Name _____

Group # _____

Contact _____

Phone # _____

Address _____

City, State, Zip _____

HEALTH FSA BENEFIT (Cafeteria Plan Year)

Plan Year Begins _____

Plan Year Ends _____

Carrier Information

Carrier Name _____

Group # _____

Contact _____

Phone # _____

Address _____

City, State, Zip _____

OTHER BENEFIT

Description _____

Effective _____ Rates Change _____

Tier Name: **Monthly Premium Rates:**

- Employee Only _____
- Employee + One _____
- Employee + Two _____
- Employee + Spouse _____
- Employee + 1 Child _____
- Employee + 2 Child _____
- Employee + Family _____
- Individually Rated _____ (attach copy of rates)
- Flat Rate _____
- Other _____

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Carrier Name _____

Group # _____

Contact _____

Phone # _____

Address _____

City, State, Zip _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

OTHER BENEFIT

Description _____

Effective _____ Rates Change _____

Tier Name: **Monthly Premium Rates:**

- Employee Only _____
- Employee + One _____
- Employee + Two _____
- Employee + Spouse _____
- Employee + 1 Child _____
- Employee + 2 Child _____
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